

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/03/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHANNONDALE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7424 MIDDLEBROOK PIKE KNOXVILLE, TN 37909</b>		
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for two residents (#14, #17) of thirty residents reviewed.</p> <p>The findings included:</p> <p>Resident #14 was admitted to the facility on September 2, 2010, with diagnoses including Aftercare Trauma Fracture Bone (pelvis), Late Effects Hemiplegia, Diabetes Mellitus, Congestive Heart Failure, and Seizure Disorder.</p>	F 280	<p><b>Shannondale Health Care Center files this plan of correction solely to satisfy State and Federal mandates. The facility does not admit that any deficiencies existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This plan of correction should not be taken as establishing any standard of care and the facility submits that the actions taken by it in response to the survey findings far exceed the standard of care. The facility offers its responses, credible allegations of compliance, and plan of correction as part of its ongoing efforts to provide quality care to residents.</b></p> <p><b>F280</b> It is the policy of this facility that a comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment. This is to be reviewed and revised by the care plan team after each assessment and after each change in the resident's condition. The care plan team consists of the MDS nurse, rehab representative, LPN, dietary representative, social service representative and an activities representative.</p> <p>For residents #14 and #17 the care plans were revised on November 3, 2010 to include the heel protectors in</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**V. P. and Administrator**

**11/15/10**

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1</p> <p>Medical record review of the Minimum Data Set (MDS) dated September 9, 2010, revealed the resident had no memory or cognitive impairment, required extensive assistance with transfers, personal hygiene, dressing, and had exhibited socially inappropriate behaviors.</p> <p>Medical record review of the resident's care plan dated September 2, 2010, revealed no documentation the resident's behaviors had been addressed.</p> <p>Observation on November 1, 2010, at 11:10 a.m., revealed the resident seated in a wheelchair in the resident's room reading a book. Continued observation revealed the resident was dressed, well-groomed, and able to carry on conversation appropriately.</p> <p>Interview with the Charge Nurse/LPN (Licensed Practical Nurse) #2 on November 3, 2010, at 10:30 a.m., at the 3rd floor nurses station, confirmed the resident had exhibited sexually inappropriate behaviors with the staff. Continued interview with LPN #2 confirmed the resident's care plan had not been revised to address the behaviors.</p> <p>Resident #17 was admitted to the facility on August 6, 2007, with diagnoses including Hypertension, Hypothyroidism, Anemia, and Venous Insufficiency.</p> <p>Medical record review of the October 2010 physician's recapitulation orders revealed "...Heel protectors when in bed..."</p> <p>Medical record review of the care plan reviewed on October 19, 2010, revealed no documentation</p>	F 280	<p><b>F-280 – continued</b></p> <p>bed for resident #17 and an appropriate behavior plan for resident #14. All residents have the potential to be affected by this practice. The MDS coordinator, MDS nurse and/or designated RN will audit 10% per month of the care plans for 100% compliance for appropriate interventions. Once achieved 10% of all care plans will be monitored quarterly for 100% compliance. Audits will be turn into and monitored by the CQI director.</p> <p>The results of these audits will be reported in the monthly CQI meetings, which consist of the medical director, administration, CQI director, director and assistant director of nursing, social services director, pharmacy director, environmental services director, dietary representative, and activity director.</p>		12-03-10

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F 280	Continued From page 2 the care plan had been revised to reflect the heel protectors while in bed.  Observation on November 2, 2010, at 10:25 a.m., revealed the resident lying on the bed without the heel protectors in place.  Interview on November 2, 2010, at 12:30 p.m., with Licensed Practical Nurse #1, in the conference room, confirmed the care plan reviewed on October 19, 2010, had not been revised to reflect the heel protectors.	F 280			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide nail care for two residents (#21, #27) of thirty residents reviewed.  The findings included:  Resident #21 was admitted to the facility on December 9, 2003, with diagnoses including Anemia, Osteoporosis, Hypertension and Senile Dementia.  Medical record review of the Minimum Data Set (MDS) dated August 10, 2009, and February 25, 2010, revealed the resident was totally dependent	F 312	<b>F312</b> It is the policy of this facility to provide the necessary services to maintain good nutrition, grooming, and personal and oral hygiene to any resident who is unable to carry out activities of daily living. For resident's #21 and #27 nail care was provided on November 3, 2010 nails were cleaned and trimmed as needed. All resident's have the potential to be affected by this practice. The licensed nursing staff will be re-in serviced on the importance of providing proper nail care. The nurses complete a weekly skin assessment on all residents which includes an assessment of fingernails and care will be provided as needed. C.N.A.s will assess fingernails daily and provide care as needed. The ongoing compliance will be monitored under the supervision of the Director of Nursing and by the R.N. House supervisor. A weekly check will be completed by the licensed nurses as they complete the skin assessments on all the residents and reports of non- compliance will be given to the house		

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F 312	Continued From page 3 on staff for personal hygiene.  Observation of the resident, in the resident's room, on November 1, 2010, at 9:00 a.m., November 2, 2010, at 2:00 p.m., and November 3, 2010, at 8:45 a.m., revealed a dark substance under the fingernails. Further observation revealed the fingernails to be overgrown with rough edges.  Observation and interview in the resident's room with the Assistant Director of Nursing (ADON) on November 3, 2010, at 9:00 a.m., confirmed the fingernails needed to be cleaned and trimmed.  Resident #27 was admitted to the facility on December 3, 2008, with diagnoses including Diabetes Mellitus, Anemia and Cognitive Disorder.  Medical record review of the MDS dated September 24, 2010, revealed "extensive assistance with personal hygiene." Medical record review of the Comprehensive Care Plan dated March 20, 2010, revealed "extensive assist of one with all ADL's (activities of daily living)."  Observation of the resident, in the resident's room on November 1, 2010, at 9:00 a.m., November 2, 2010, at 2:45 p.m., and November 3, 2010, at 8:30 a.m., near the nurse's station on third floor revealed discolored overgrown finger nails.  Interview on November 3, 2010, at 9:00 a.m., with the ADON in the third floor activity area, confirmed the resident's fingernails needed to be trimmed.	F 312	<b>F312 - continued</b> Supervisor on that shift and then reported to the Director of Nursing. Any deficient practice will be corrected immediately. Problems will be reported to the CQI director and reviewed in the monthly CQI meeting. The CQI committee consists of the medical director, administration, CQI director, director and assistant director of nursing, social services director, pharmacy director, environmental services director, dietary representative, and activity director.	12-03-10
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	<p>Continued From page 4</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure medications designated for</p>	F 431	<p><b>F431</b></p> <p>It is the policy of this facility to employ the services of a licensed pharmacist who ensures drugs and biological used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The medications identified as expired were removed immediately from the emergency boxes and replaced on November 3, 2010.</p> <p>The pharmacy staff will be in-serviced by the pharmacy director regarding checking for expired medications. To prevent a recurrence of this practice a pharmacy tech will audit all emergency medication boxes weekly for one quarter. If 100% compliance is then achieved then the emergency boxes will be audited monthly; this will be monitored by director of pharmacy services. The pharmacy consultant will check the medication room monthly and report any expired medications to the pharmacy director.</p> <p>The results of these audits will be reported in the monthly CQI meetings, which consist of the medical director, administration, CQI director, director and assistant director of nursing, social services director, pharmacy director, environmental services director, dietary representative, and activity director.</p>	12-03-10	

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F 431	Continued From page 5 emergency use were safe for administration in one emergency box of three medication preparation rooms observed.  The findings included:  Observation on November 3, 2010, at 10:40 a.m., revealed the contents list on the top of the emergency medication box stored in the third floor medication preparation room had "Dextrose 50%" (intravenous medication) (IV) with an expiration date of March 1, 2010. Observation at this time revealed LPN #2 unlocked the emergency box and revealed two packages of the 50% Dextrose product with expiration dates of March 1, 2010, stored inside the emergency box.  Interview on November 3, 2010, at 10:40 a.m., in the medication preparation room on the third floor with Licensed Practical Nurse #2 confirmed the IV medication had expired.	F 431			
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	<b>F441</b> It is the policy of this facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The staff member that failed to properly clean equipment after use and failed to properly wash hands after donning off gloves was re-in-serviced by the In- service Coordinator on November 11, 2010. The LPN that mishandled the medication during the medication pass was re-in-serviced by the Director of Nursing on November 4, 2010 on the proper handling of medication during the medication pass.		

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F 441	<p>Continued From page 6</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to appropriately clean equipment after use, the staff failed to wash the hands after providing care for one resident (#3) of thirty residents reviewed, and failed to administer a medication in a sanitary manner during a medication pass.</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on February 16, 2005, with diagnoses including Urinary Tract Infection, Diabetes, Peripheral Vascular Disease, Chronic Kidney Disease, and Dementia.</p>	F 441	<p><b>F441 - Continued</b> All residents have the potential to be affected by the cited deficiency, under the direction of the Director of Nurses the In-service Coordinator will provide re-in-services for licensed staff regarding infection control practices for proper cleaning of equipment, hand washing, and handling of medications during the medication pass. To further ensure compliance random audits will be completed on proper cleaning of equipment, hand washing and medication administration by the Infection Control Nurse, the In-service Coordinator and nursing administration. The audit will be reviewed by the Infection Control Nurse and noted deficiencies will be evaluated and education provided as needed. The results of these audits will be reported in the monthly CQI meetings, which consist of the medical director, administration, CQI director, director and assistant director of nursing, social services director, pharmacy director, environmental services director, dietary representative, and activity director.</p>		12-03-10

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F 441	<p>Continued From page 7</p> <p>Medical record review of a preliminary wound culture report dated October 21, 2010, revealed "...Result 1 Gram negative rods...Result 2 Proteus mirabilis..." Continued medical record review of the preliminary wound culture report revealed the gram negative rods and Proteus mirabilis were susceptible to Amoxicillin (antibiotic).</p> <p>Medical record review of a physician's order dated October 21, 2010, revealed Amoxil (antibiotic) 400 mg (milligrams) was to be administered three times a day for ten days.</p> <p>Medical record review of a wound culture dated October 22, 2010, revealed "...Final report...Result 1 Escherichia coli...Result 2 Proteus mirabilis...Result 3 Staphylococcus aureus Methicillin resistant (MRSA)..." Continued medical record review of the wound culture dated October 22, 2010, revealed the MRSA was not susceptible to the Amoxicillin. Continued medical record review of the wound culture dated October 22, 2010, revealed the Nurse Practitioner had initialed the laboratory report as reviewed on October 25, 2010. Medical record review revealed no documentation an antibiotic was ordered to treat the MRSA.</p> <p>Observation on November 2, 2010, at 10:00 a.m., with Registered Nurse (RN) #1, revealed the resident lying on the bed, on the left side, exposing a dressing covering the wound on the sacrum. Continued observation revealed RN #1 removed the dressing from the wound and described the wound as a Stage II ulcer measuring 2.1 cm (centimeters) by 1.0 cm with an approximate depth of 0.2 cm., with a small</p>	F 441		

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F 441	<p>Continued From page 8 amount of serous drainage.</p> <p>Interview on November 1, 2010, with RN #2, in the conference room, revealed RN #2 was unaware the wound culture dated October 22, 2010, was positive for MRSA. Continued interview revealed RN #2 would contact the Nurse Practitioner.</p> <p>Medical record review of a Nurse Practitioner's order dated November 1, 2010, revealed "Tetracycline (antibiotic) 500 mg po (by mouth) TID (three times a day) X (times) 7 days..."</p> <p>Medical record review of a note written on the physician's progress notes dated November 1, 2010, revealed "Wound culture MRSA...(sensitive to) Tetracycline..."</p> <p>Observation on November 1, 2010, at 11:15 a.m., revealed Certified Nursing Assistant (CNA #1) transported the resident from the shower room, located across the hall from the resident's room, in a wheeled shower chair. Continued observation revealed the resident was covered with a sheet and the bare buttocks were on the shower chair seat. Observation on November 1, 2010, at 11:30 a.m., revealed RN #1 and CNA#1 were providing care to the resident. Observation revealed while RN #1 was providing wound care to the resident, CNA #1 exited the room to return the shower chair to the shower room. Continued observation revealed CNA #1 returned to the resident's room, and after RN #1 completed the wound care and exited the room, CNA #1 continued to provide care to the resident. Continued observation revealed CNA #1, with gloved hands, applied an incontinence brief and clothing to the resident. Continued observation</p>	F 441			

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F 441	<p>Continued From page 9</p> <p>revealed CNA #1 rolled the resident side to side in order to position the resident's pants and to place a mechanical lift sling under the resident. Continued observation revealed CNA #1 removed the gloves and without washing the hands or using hand sanitizer, exited the room and obtained a mechanical lift from the hallway. Continued observation revealed CNA #1 returned to the resident's room, hooked the sling to the mechanical lift, transferred the resident to a chair, and returned the mechanical lift to the hallway. Continued observation revealed CNA #1 returned to the resident's room and without washing the hands or using hand sanitizer, applied gloves, brushed the resident's hair, removed the gloves and without washing the hands or using hand sanitizer, checked and applied a safety alarm, placed pillows behind the resident's head and legs, applied a throw over the resident's legs, and placed the soiled linen into the soiled linen cart located in the hallway. Continued observation revealed CNA #1 returned to the resident's room and applied hand sanitizer to the hands.</p> <p>Review of the facility's policy Cleaning and Disinfection of Shower Chairs/Shower Beds revealed "Purpose: To provide supplies and equipment that are adequately cleaned or disinfected...Shower chairs/beds will be cleaned immediately after each use. Cleaning may be done in the shower room using disinfectant wipes..."</p> <p>Review of the facility's policy When to Wash Hands revealed "Before touching a patient, After touching a patient...After touching any item used by or for a patient..."</p> <p>Interview on November 1, 2010, at 12:10 p.m.,</p>	F 441			

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F 441	Continued From page 10 with CNA #1, in the lobby, revealed CNA #1 had cleaned the shower chair with soap and water, after returning the shower chair to the shower room, and confirmed the disinfectant wipes were not used to clean the shower chair.  Interview on November 2, 2010, with RN #1/Infection Control Coordinator, in RN #1's office, revealed the hands were to be washed after each time the gloves were removed, and confirmed appropriate hand hygiene was not completed.  Observation on November 2, 2010, at 8:25 a.m., during medication administration revealed LPN #2 dropped a pill on the top of the medication cart, picked it up with bare fingers, placed it in the medication cup, and administered it to the resident.  Interview with LPN #2 on November 2, 2010, at 8:25 a.m., confirmed the medication had not been administered in a sanitary manner.	F 441			
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to provide timely laboratory services for one resident (#24) of thirty residents reviewed.  The findings included:	F 502	<b>F502</b> It is the policy of this facility to provide or obtain laboratory services to meet the needs of the residents. For resident #24, the resident was treated with an antibiotic with no adverse effect.  All residents with signs and symptoms of urinary tract infections have the potential to be affected by the practice. The policy for obtaining urinalysis, urine cultures and sensitivities, has been reviewed and revised to include, urine specimens are to be obtained within 24 hours of being ordered, unless otherwise specified by		

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F 502	Continued From page 11  Resident #24 was admitted to the facility on October 3, 2008, with diagnoses including Atrial Fibrillation, Chronic Pain Syndrome, Insomnia, and Diabetes Mellitus, Type 2.  Medical record review of a physician's order dated October 22, 2010, revealed "... UA C&S (urinalysis, urine culture, and sensitivity) ..."  Medical record review of a nurse's note dated October 25, 2010, revealed "...urine for urinalysis ...obtained." Further medical record review of the nurse's notes dated October 20-30, 2010, revealed no documentation of any attempts to collect a urine specimen as ordered on October 22, 2010.  Interview with the Director of Nursing, November 3, 2010, at 10:10 a.m., in the conference room, confirmed the urine specimen was not collected until October 25, 2010 (3 days later).	F 502	<b>F502 – Continued</b> the physician. The licensed nursing staff will be in-serviced on this procedure. Ongoing compliance will be monitored, under the supervision of the Director of Nursing, by the R.N. house supervisor. Any deviations from this practice will be immediately reported to nursing administration. Problems will be reported to the CQI Director and reviewed in the monthly CQI meetings which consist of the medical director, administration, CQI director, director and assistant director of nursing, social services director, pharmacy director, environmental director, dietary representative and activity director.		12-03-10
F 505 SS=E	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS  The facility must promptly notify the attending physician of the findings.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to promptly notify the physician of the laboratory results for four (#3, #23, #24, and #25) of thirty residents reviewed.  The findings included:  Resident #3 was admitted to the facility on	F 505	F505 It is the policy of this facility to promptly notify the attending physician of lab results.  For resident #3, #23, #24 and #25, all residents involved were treated with appropriate antibiotics with no adverse effects.  Any resident with abnormal culture results have the potential to be affected. The nursing supervisors will be in-serviced on calling all abnormal culture results to the physician or nurse practitioner on the day the results are received.		

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F 505	<p>Continued From page 12</p> <p>February 16, 2005, with diagnoses including Urinary Tract Infection, Diabetes, Peripheral Vascular Disease, Chronic Kidney Disease, and Dementia.</p> <p>Medical record review of a physician's order dated October 19, 2010, revealed a wound on the sacrum was to be cultured to rule out yeast. Continued medical record review of the physician's order dated October 19, 2010, revealed Diflucan (antifungal) 200 mg (milligrams) was ordered three times a day.</p> <p>Medical record review of a wound culture dated October 22, 2010, revealed "...Final report...Result 1 Escherichia coli...Result 2 Proteus mirabilis...Result 3 Staphylococcus aureus Methicillin resistant (MRSA)..."</p> <p>Medical record review revealed no documentation the physician or Nurse Practitioner was notified of the final report of the positive wound culture dated October 22, 2010, until the Nurse Practitioner initialed the report on October 25, 2010.</p> <p>Interview on November 2, 2010, at 9:40 a.m., with the physician and the Director of Nursing, in the conference room, revealed positive wound cultures were to be reported to the physician when the facility obtained the report and confirmed there was a delay in notifying the physician or Nurse Practitioner of the positive wound culture.</p> <p>Resident #23 was admitted to the facility on February 6, 2007, with diagnoses including Chronic Urinary Tract Infection, Dementia with Behavior Disturbance, Hypertension, and Irritable Bowel Syndrome.</p>	F 505	<b>F505 - Continued</b> Ongoing compliance will be monitored, under the supervisor of director of nursing services by the R.N. house supervisor. Audits will be done weekly until 100% compliance is achieved and then monthly for six months and the quarterly. Results will be reported in the monthly CQI meeting, which consist of the medical director, administration, CQI director, director and assistant director of nursing, social service director, pharmacy director, environmental services director, dietary representative and activity director.	12-03-10	

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F 505	<p>Continued From page 13</p> <p>Medical record review of a physician's order dated July 2, 2010, revealed "UA &amp; C&amp;S" (urinalysis and culture and sensitivity). Medical record review of a progress note, written on the physician's progress notes, dated July 2, 2010, revealed "Resident having pain, pressure &amp; c/o (complains of) frequency when vding (voiding)."</p> <p>Medical record review of a laboratory report dated July 4, 2010, revealed a positive urine culture with the causative organism Klebsiella pneumoniae.</p> <p>Medical record review revealed no documentation the Nurse Practitioner or physician was notified until July 6, 2010, when an order was obtained to administer Cipro (antibiotic) 500 mg twice a day for five days.</p> <p>Interview on November 3, 2010, at 10:10 a.m., with the Director of Nursing, in the conference room, confirmed the delay in notifying the Nurse Practitioner or Physician of the positive urine culture.</p> <p>Resident #24 was admitted to the facility October 3, 2008, with diagnoses including Atrial Fibrillation, Chronic Pain Syndrome, Insomnia, and Diabetes Mellitus, Type 2.</p> <p>Medical record review of a physician's order dated October 22, 2010 revealed "... UA C&amp;S (urinalysis, urine culture, and sensitivity ..."</p> <p>Medical record review of a nurse's note dated October 25, 2010, revealed "...urine for urinalysis...obtained."</p>	F 505		

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F 505	<p>Continued From page 14</p> <p>Medical record review of a laboratory report dated October 25, 2010, revealed the resident's urine was positive for Escherichia coli. Further medical record review of the laboratory report revealed the organism was sensitive to nitrofurantoin.</p> <p>Medical record review of a nurse's note dated October 27, 2010, revealed "...UA C&amp;S report called to...NP (nurse practitioner). Resistant to most antibiotics, NP will f/u in am..."</p> <p>Continued medical record review of a physician's order dated October 28, 2010, revealed "...Macrobid (nitrofurantoin) 100 mg. (milligrams) PO (by mouth) x 10 days."</p> <p>Interview with the Director of Nursing, on November 3, 2010, at 10:10 a.m., in the conference room, confirmed the facility failed to notify the nurse practitioner of the positive urine culture on October 25, 2010, when the lab results were received from the laboratory until October 27, 2010, (two days later) .</p> <p>Resident #25 was admitted to the facility June 22, 2007, with diagnoses including Urinary Tract Infection, Hypertension, Mental Disorder, and Chronic Airway Obstruction.</p> <p>Medical record review of a physician's order dated August 19, 2010, revealed "...UA C&amp;S (urinalysis, urine culture, and sensitivity)..."</p> <p>Medical record review of the laboratory report dated August 20, 2010, revealed the Resident's urine was positive for Escherichia coli. Further medical record review of the laboratory report revealed the organism was sensitive to ceftriaxone (Rocephin).</p>	F 505			

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F 505	Continued From page 15  Continued medical record review of a physician's order dated August 23, 2010, revealed "...Rocephin 1 gram IM x 5 days..."  Interview with the Director of Nursing, November 3, 2010, at 10:10 a.m., in the conference room, confirmed the facility failed to notify the physician of the positive urine culture on August 20, 2010, when the lab results were received from the laboratory, until August 23, 2010 (three days later).	F 505			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accurately document the enteral feeding flow rate for one resident (#22) of thirty residents reviewed.  The findings included:	F 514	<b>F514</b> It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.  For resident #22 the medical record was reviewed and addendums were completed to correct the inaccurate documentation on July 25 and 26; August 1, 2, 8 and 15; September 5 and 6.  All residents receiving tube feedings have the potential to be affected by this practice. Under the direction of the Director of Nursing the clinical records of the residents receiving tube feeding were reviewed on November 12, 2010 by nursing administration for 100% compliance. The licensed nursing staff will be inserviced on proper documentation of tube feeding rates. Audits will be		

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F 514	<p>Continued From page 16</p> <p>Resident #22 was admitted to the facility on August 21, 2009, with diagnoses including End Stage Renal Disease, Dysphagia, and Mental Disorder.</p> <p>Medical record review of a Physician's Order dated July 22, 2010, revealed the resident's flow rate for the tube feeding was increased from 50 ml/hr (milliliters per hour) to 55 ml/hr.</p> <p>Medical record review of the nurse's notes dated July 25th and 26th, 2010, August 1st, 2nd, 8th, and 15th, 2010, and September 5th and 6th, 2010, revealed the resident received the tube feeding at 50 ml /hour.</p> <p>Review of the facility's "Completed Care Tasks" document (an electronic document) revealed the resident received the tube feeding at 55 ml/hr. on July 25th and 26th, 2010, August 1st, 2nd, 8th, and 15th, 2010, and September 5th and 6th, 2010.</p> <p>Interview with the Director of Nursing on November 3, 2010, at 2:41 p.m., in the conference room confirmed the medical record was not accurate.</p>	F 514	<p><b>F514 - Continued</b></p> <p>completed by the house supervisors monthly on the clinical record for proper documentation of all residents requiring tube feeding. Any inaccurate documentation will be noted.</p> <p>Audits will be completed monthly until 100% compliance has been achieved and then quarterly until 100% compliance achieved. The process will be monitored under the supervisor of director of nursing services by the R.N. house supervisor.</p> <p>The results of these audits will be reported in the monthly CQI meetings, which consist of the medical director, administration, CQI director, director and assistant director of nursing, social services director, pharmacy director, environmental services director, dietary representative, and activity director.</p>		12-03-10

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